Aug 14 '57

# Oral Hygiene

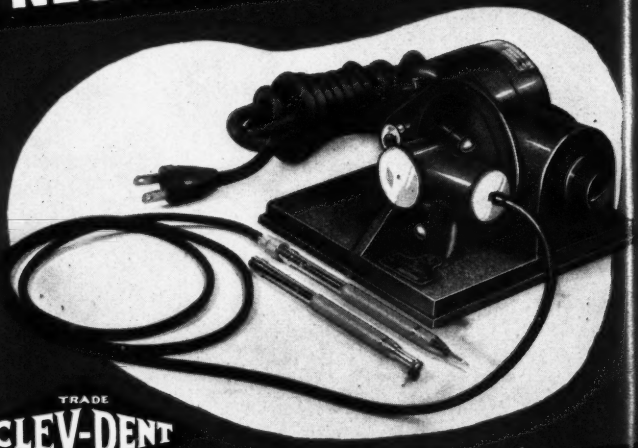
AUGUST 1957

Manitou and Pikes Peak Cog Railway train en route to the summit of Pikes Peak. The annual meeting of the Colorado State Dental Society will be held October 6 to 9 in Colorado Springs.

*In this issue:*

**GET THE VIEWS OF THE PATIENTS!**

# The PNEUMATIC CONDENSER



TRADE CLEV-DENT MARK

**For Denser Gold Foil and Amalgam Fillings**

A time saving and efficient air hammer which, due to its consistency of pressure, will build homogenous gold foil and amalgam restorations.

The pneumatic condenser stimulates the use of gold foil and in the construction of amalgam restorations it is a valuable aid in obtaining unchanging results.

*Full Details on Request*

**Serving the Profession since 1893**

## The Cleveland Dental MANUFACTURING COMPANY

CLEVELAND 1, OHIO

*Relieves Pain Faster,*
*More Effectively*

A combination of analgesics, such as aspirin, acetophenetidin, and caffeine has been clinically proven to exercise a smoother and more effective action than equivalent doses of any one used individually.[1,2] Anacin is such a formulation. Anacin acts quickly to raise the pain threshold and affords prolonged relief. There is no gastric upset—Anacin does not upset the stomach. Faster-acting, long-lasting, better tolerated—this greater total effect in pain relief is why more dentists prefer and recommend Anacin than any other analgesic.

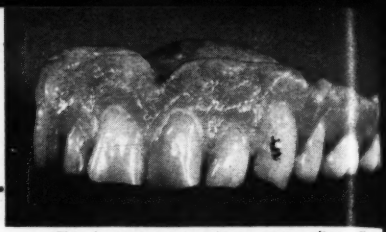
*always* **ANACIN**®

for better relation between dentist and patient

References: 1. Hammes, E. M., Jr.: *Journal-Lancet* 72:67, 1952. 2. Goodman, Louis S. and Gilman, Alfred: *The Pharmacological Basis of Therapeutics*, second ed., 1955.

**FULL DENTURES**

Swissedentures
Oracrylic 55
Tinted Base
Vitallium® Palate
Anatomical Set-up



This denture creates vigorous masculine effect for middle-aged man through characteristic tooth form, personalized modification and arrangement with distinctive shading.

# The Full Scope of Boos Service is *Right at Your Fingertips*

## ONE OF MANY WAYS YOUR PRACTICE BENEFITS WITH BOOS COMPLETE LABORATORY SERVICE

Here, in one organization, you have the skill, experience and facilities for every type of laboratory service. For over fifty-five years dentists throughout the country have depended on it for consistent high quality in the more complex as well as the average type of case.

It is a prompt, personal service, easily available to you, no matter where you practice.

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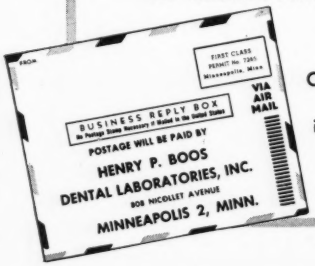
We pay postage and charge it to your account.

Our own hourly mail service to and from the post office ensures immediate attention to your cases and fast delivery of completed restorations to your office.

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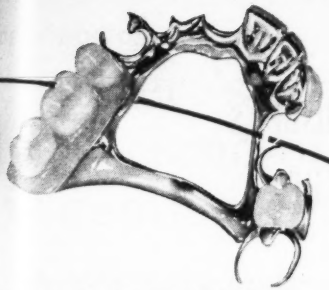
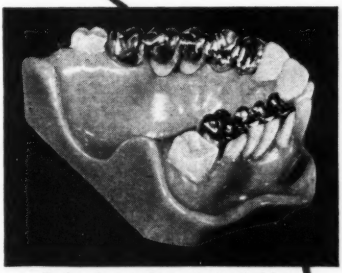


## PARTIAL DENTURES

Micro-Analyzing
Veri-Thin Cast Vitallium®
Cast Gold
Precision Attachment
Stress Breaking
Wrought-Wire

Accuracy, function and esthetics in all types of partial dentures are achieved by intelligent analysis, combined with Boos technical skill and scientific methods.



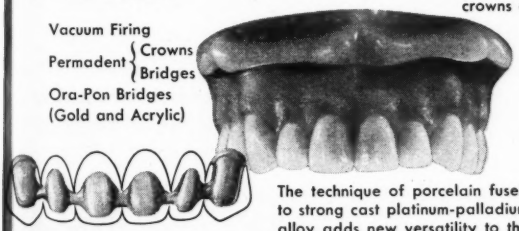
## GOLD CROWNS AND BRIDGES

Porcelain Tips
Cast—Soldered
Veneers
Indirect Techniques

Every day at Boos, twelve bridge technicians with 320 years of combined experience, put their skill and judgment to work constructing truly esthetic and functional gold crowns and bridges.

## PORCELAIN JACKETS AND BRIDGES

Vacuum Firing
Permadent { Crowns / Bridges }
Ora-Pon Bridges
(Gold and Acrylic)



The technique of porcelain fused to strong cast platinum-palladium alloy adds new versatility to the ideal esthetic restorative material —porcelain.

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DENTAL LABORATORIES, INC.

## OTHER SPECIALIZED SERVICES

Oral Orthopedics • Orthodontic Appliances • Cleft Palate Restorations • Implant Dentures • And Many Others

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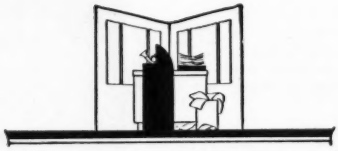
MINNEAPOLIS 2, MINN.

EST. 1902

Branch Laboratories: *Medical Arts Bldg., Duluth, Minn.* • *Equitable Bldg., Des Moines, Iowa*

# The Publisher's CORNER

**By Mass**



**No. 433**

## GEORGE AND ARTHUR AND ED

LAST MONTH, this column told about an old, old newspaper—the St. Louis *Daily Evening Gazette* for December 29, 1838, which carried several dentists' advertisements, some of which we quoted.

Now we're back rustling newspapers again—younger newspapers, however. One is the New York *Journal-American* which carries E. V. Durling's column. An old friend, Perc Phillips of Brooklyn, sent it to me.

Durling asked, "Who is the oldest active dentist in this country? How about 82-year-old Dr. George Cunningham Sharp of Pasadena, California, who has been practicing dentistry for 60 years and is still going strong?"

How about Doctor Arthur T. White, also of Pasadena? An old friend of ours, Arthur is 88 years old and has been in practice for 66 years. Last year, in the September 1956 issue, ORAL

August 1957. Monthly. Oral Hygiene, Inc., 1005 Liberty Ave., Pittsburgh, Pa. Subscription, $5.00 a year in U.S., Canada and Latin America; $5.75 elsewhere. Accepted as controlled circulation publication at Rutherford, N.J.

*DEAR DOCTOR:*

# Here's why no other kind of laxative is gentler, yet so fast acting

### *SAL HEPATICA® is gentle*

It creates a gentle moist bulk, drawing water into the intestine by osmotic action, thus exerting a soft, gentle pressure initiating the proper intestinal response that is the very mechanism which produces normal elimination.

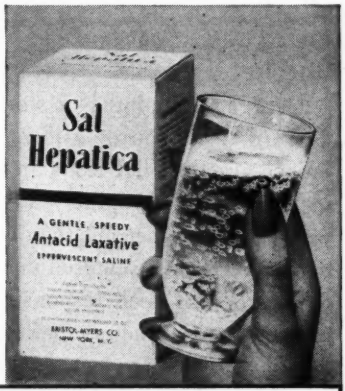
It contains no harsh chemical irritants to stimulate intestinal overactivity—the condition that often causes griping and cramping.

### *SAL HEPATICA is fast acting*

SAL HEPATICA gives prompt relief from constipation. When taken one-half hour before breakfast, your patients will get relief usually within the hour.

Or when taken one-half hour before supper, it will provide relief by bedtime. It will not interfere with work or sleep.

SAL HEPATICA, because it is antacid, helps relieve the hyperacidity which so frequently accompanies constipation—and its antacid action speeds it into the intestine.




APERIENT

LAXATIVE

CATHARTIC

**SAL HEPATICA has a sound pharmacologic basis. It is both effervescent and antacid.**

"The emptying time of the stomach is actually shortened by reducing the gastric acidity."[1]

"Effervescent mixtures decrease the emptying time of the stomach."[2]

1. The Physiological Basis of Medical Practice. 1945, p. 486.
2. New England J. Med. 235: 80 (July 18) 1946.

Bristol-Myers Co. • 19 West 50 Street • New York 20, N. Y.

HYGIENE saluted Arthur and printed a fine picture of him. Over the years, Arthur has been an occasional contributor to the CORNER.

He has an uncanny special sense which somehow tells him when the publisher needs cheering up. You come in here dragging your feet, moaning low about life in general and your own life in particular—and look! Here's a letter from Arthur. Bless that man!

Arthur graduated from the University of Indiana in 1892. He served as president of the Indiana State Dental Association in 1907. Three years later, he and his family moved to California.

Now comes a letter from another old friend, George Lockman of Seattle. George sent a clipping from the Seattle *Post-Intelligencer*, which somehow got stuck in the "urgent" file until just now.

George's clipping is a story by Sam Angeloff about Doctor Edward C. Kilbourne of Seattle, who is 102. Apparently he no longer practices but leads an active life otherwise. He was born in Vermont in 1856, the year the Indians attacked Seattle, which was destined to become the doctor's home town starting in 1883, not long before he entered dental practice. Civic-minded, Doctor Kilbourne has been responsible for helping stimulate Seattle's growth. Says the newspaper story, "His schedule of appearances would wear out a young man, but he likes to keep busy." A man is only as old as he thinks he is, the doctor believes.

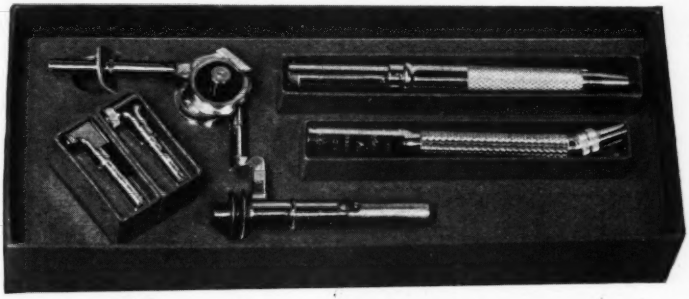
So far, it seems likely that Arthur White holds the top spot. But you never can tell. Whatever the score, it won't worry Arthur.

# IMPERATOR...

## fabulous, yes!

## And, surprisingly INEXPENSIVE, too!

Now Experience Famous Imperator
Control and Precision for ONLY **$118.50**



**NEW 5-PIECE IMPERATOR OUTFIT**

***Imperator Wrist Pulley***
***Imperator Angle Handpiece***
***Straight Handpiece****
***Imperator Head***
***Latch-Type Head****

All you need for your most gratifying handpiece experience for **ONLY $118.50.**

Also available as described with Imperator Speed Increasing Wrist Pulley instead of standard Imperator Wrist Pulley. Increases speed approximately *three times* without increasing belt speed . . . **ONLY $140.50.**

*Order the Imperator Outfit which best suits your needs from your KERR dealer today.*

For the ultimate in vibration-free performance select an assortment of Imperator Cutting Instruments, too. After one day with the Imperator, Doctor, you will be convinced it is the best investment you will ever make.

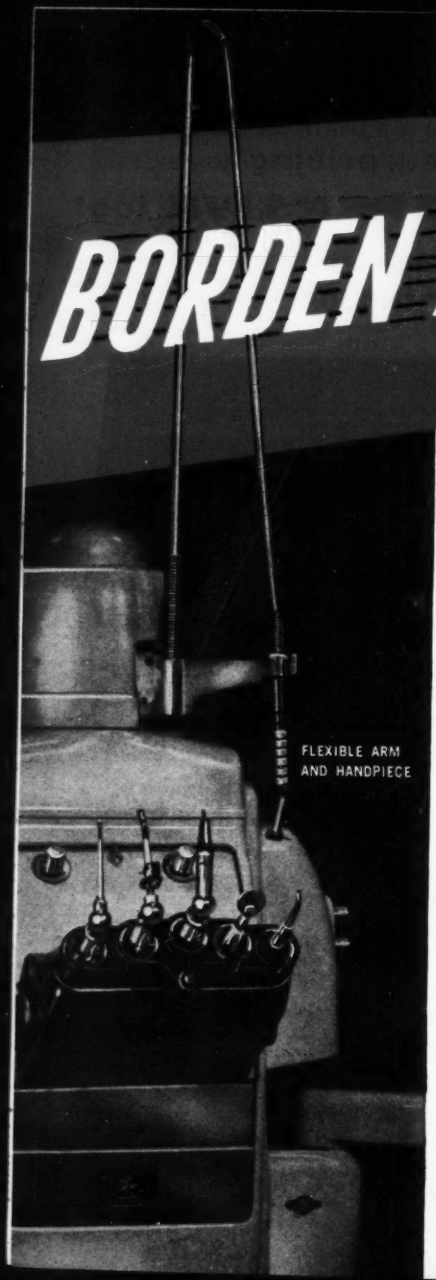
KERR

***Enables you to use any of your present cutting instruments.**

**IMPERATOR OUTFIT**

**ERR MANUFACTURING COMPANY** • *Established 1891* • **DETROIT 8, MICHIGAN**

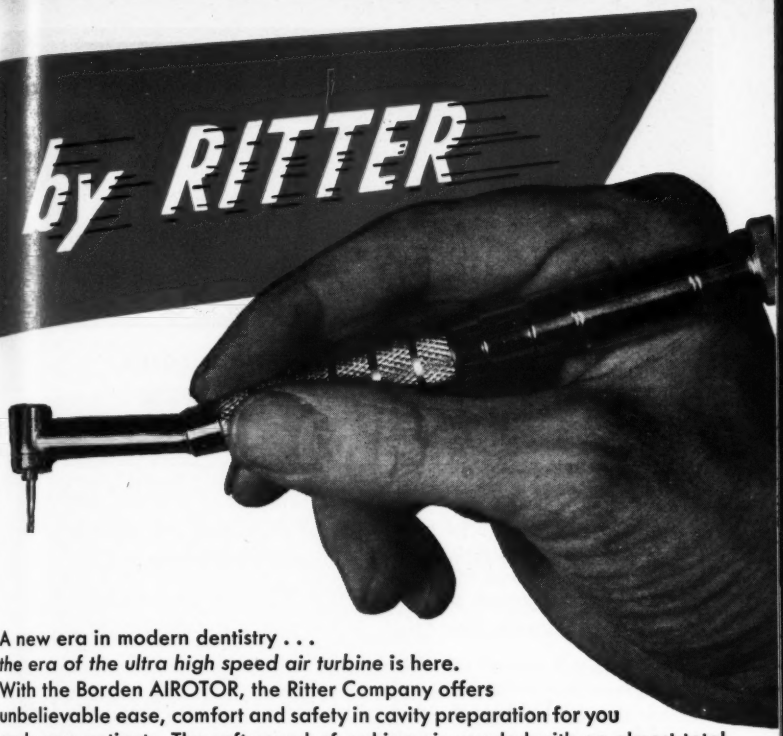
# BORDEN AIROTOR




## . . . the Most Significant Advance in Modern Cavity Preparation!

**MAXIMUM SAFETY WITH**
**FEATHER-TOUCH CONTRO**
**AT ULTRA HIGH SPEED**

# by RITTER



A new era in modern dentistry . . .
*the era of the ultra high speed air turbine* is here.
With the Borden AIROTOR, the Ritter Company offers unbelievable ease, comfort and safety in cavity preparation for you and your patients. The soft sound of rushing air coupled with an almost total lack of vibration opens a new world of experience for your patients. You have absolute control of the lightweight handpiece with only the lightest pressure needed for operative procedures. In addition, the Borden AIROTOR offers these outstanding features:

- **Handpiece speeds from 100,000 to 200,000 R.P.M.**
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- **Built-in air and water coolant at the bur actuated by foot control (air only if desired)**

Your Ritter dealer is ready to demonstrate the many outstanding features of the Borden AIROTOR on the Ritter H Unit or as a separate Universal Package for any unit. Call him today.

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A.D.A. ANNUAL SESSION
MIAMI • MIAMI BEACH
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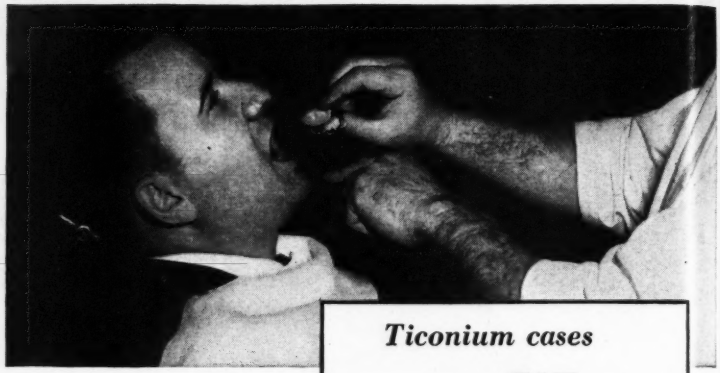


*Ticonium cases*

**FIT—**

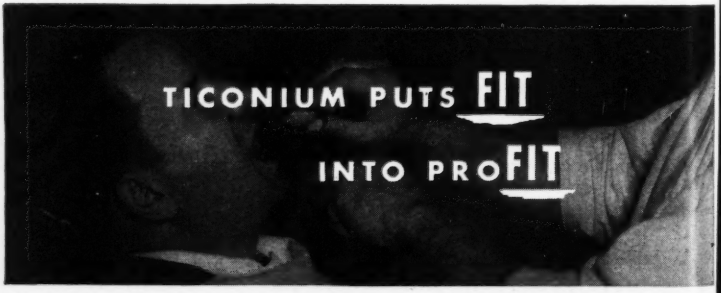
That crucial moment at the chair when you put the case in the patient's mouth, makes the difference.

Ticonium cases are cast to fit — not ground to fit! That means time saved at the chair and patient satisfaction.

**Ticonium cases put the fit into profit, Doctor**

**TICONIUM**

DIVISION OF CONSOLIDATED METAL PRODUCTS CORP.
ALBANY 1, NEW YORK



# Now from American Sterilizer

## *MODEL 613-K PORTABLE HIGH-SPEED AUTOCLAVE

***New HIGH in performance***
***New LOW in cost***

* The newest product of the world's largest manufacturer of Pressure Steam Sterilizers

*Compare*
**THESE FEATURES:**

- **All Stainless Steel**
  For durability and easy cleaning
- **Positive Sterilization**
  Pressure steam at 250° F. to 270° F.
- **Greater Capacity**
  Holds three large trays (6" x 13")
- **Fast**
  Reaches 270° F. in approximately seven minutes
- **Automatic**
  Times any selected sterilizing cycle
- **Cool and Dry**
  Dries instruments or supplies by exhausting steam and residual water back into water reservoir . . . NOT into room
- **Safety-Lock Door, Adjustable Thermostat and Accurate Temperature Gauge**
  Automatically "burn-out" proof

*See your authorized American Sterilizer Dealer or write for Bulletin DC-410.*

AMERICAN STERILIZER
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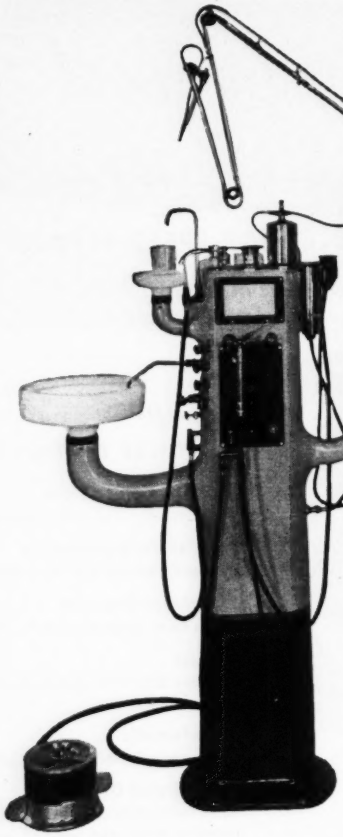

# THE NEW NO. 4 UNIT

## AT NO INCREASE IN PRICE

- Many new features have been added.
- Vacuum Breaker which controls all water outlets.
- New Design for Motor Mounting which accommodates High Speed Pulleys.
- A New High-Low Speed Switch for the Motor.

- You will also note from the photographs that the Hanau THERM-EX-SPRAY with Dual Control can be added, as well as the High Speed Pulley.
- With the High Speed Pulley, you can obtain a Handpiece speed of approximately 30,000 R.P.M.
- Here's the latest in Dental Equipment at practically half the cost of other Units with similar features.

**CENTRAL DENTAL MANUFACTURING CO., INC.**

640 South 3rd Street, Louisville, Ky.

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1950
1951
1952
1953
1954
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1956
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# Proven...

## by the Test of Time!

**SUPERIOR SEVRITON** ACRYLIC FILLING MATERIAL

Time alone is daily proving to countless dentists the claims made for SEVRITON Acrylic Filling Material on its introduction seven years ago. They now know that —

**SUPERIOR SEVRITON**

- **Has perfect, lasting color match with natural teeth.**
- **Produces a dense, durable filling.**
- **Has marginal adaptation that really lasts.**
- **Defies detection after years in the mouth.**

*Remember* there's no better test of a product's worth than TIME. Use the proven, superior acrylic filling material — use SEVRITON.

"SEVRITON"
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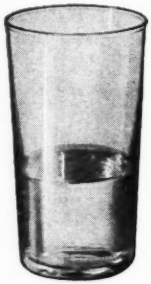
manufactured by
The Amalgamated Dental Co., Ltd.,
London, England, under license
from De Trey Frères, S.A.
Zurich, Switzerland.

*Claudius Ash, Sons & Co., U.S.A., Inc.*

309 Main Street Niagara Falls, N. Y.

# effective and economical

*you add just a few drops . . . to a quarter glass of water*

## concentrated ASTRING-O-SOL®

The effectiveness of Astring-o-sol is measured *in drops — not drams — not ounces.* Its tangy, invigorating taste and mild astringent action leave the mouth fresh and sweet. Astring-o-sol is an effective deodorant — and kind to the most delicate oral tissues too. A little goes a long way . . . at the chair and in daily mouth care.

American Ferment Company, Inc.
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**write for samples for patient distribution**

Accepted
COUNCIL ON DENTAL THERAPEUTICS
AMERICAN DENTAL ASSOCIATION

Better denture adherence with **KLING®**
using only N. F. gums

Write for professional samples

# *new* BELLEVIEW® TOWELS

soft, disposable
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4-ply laminated facial tissue
folded only twice to reduce wrinkles
overall size 18" x 13½"
available in convenient dispensing
cartons of 50 (cases of 500)

## pleasing on the patient
## ...easy on the budget

Belleview towels — formerly Johnson's Pinafores —
now a new name, a new package, a better product

Johnson & Johnson

DENTAL DIVISION

# Denture Technique and Alkalinity...

FASTEETH is made exclusively by
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• Tender gum tissues, unaccustomed to the pressure of a new denture, sometimes become sensitive and irritated. FASTEETH, buffered to maintain a mild alkalinity in contact with the tissues, checks and soothes soreness and inflammation due to chafing and hyperacidity.

When tissues are so irritated that they react unfavorably to the new denture the period of adjustment and adaptation may be prolonged unduly. FASTEETH'S sustained and mild alkalinity helps patients to tolerate new dentures quicker and more easily.

# GE-90 / *a General Electric product in step with your progress*

## "that exposure took only 1/15 second!"

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*Progress Is Our Most Important Product*

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*with Gum-Aid, patients quickly*

*forget they're wearing dentures*

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# Gum-Aid

# PERFORMS ALL FIVE FUNCTIONS

1. **HOLDS DENTURES**—It's adhesive—lasts approximately 24 hours. Doesn't dilute with saliva.
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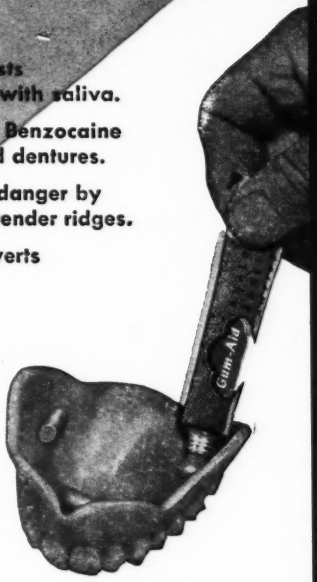
5. **HASTENS ADJUSTMENT**—By stablizing restorations, confidence and denture mastery are quickly established.





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**FOR AUGUST ONLY**

**3 Boxes** TOTAL 18 TUBES **$7.50** YOU SAVE $1.50

**Standard Price: 1 Box of 6 Tubes, $3**

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## NOW...ATARAX RELAXES NERVOUS PATIENTS

ATARAX saves chair-time lost to "drill-consciousness" or chair fear. For patients who are resistant . . . nervously talkative . . . for those who require long procedure preparation . . . and restless children . . . ATARAX brings peace-of-mind calmness in the dentist's office.

SAFELY: "The digestive and general tolerance was perfect."[1] And ATARAX does not cause mental fogging. After his appointment the patient returns to his job or classroom with a clear mind. Safe for children, too.

SWIFTLY: ATARAX generally takes effect within 15 minutes.

FLEXIBLY: Pleasing ATARAX Syrup particularly suits office needs. Two tsp. (20 mg.) usually soothes patients within 15 minutes; a single 25 mg. tablet achieves the same effect. Or you can prescribe 5 or 10 ATARAX Tablets for the patient to take at home. Suggest one tablet 2 or 3 hours before each visit.

1. Bayart, J.: International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956

# PEACE OF MIND ATARAX®

(BRAND OF HYDROXYZINE) *Tablets-Syrup*

*Send in the coupon for free samples, Rx pads, and descriptive literature.*

To: Box D, J. B. Roerig and Company, 800 Second Avenue (at 42nd Street)
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ROERIG Rx

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Name:_____ Samples ☐

Rx Pads ☐

Address:_____ Literature ☐

# NEW CLINICAL EVIDENCE

Confirms anti-caries effectiveness of stannous fluoride as used in

*Crest toothpaste with Fluoristan*

*Clinical Study No. 4*

REPORTED MAY, 1957, THE JOURNAL OF THE AMERICAN DENTAL ASSOCIATION

Results after one year: 35% caries reduction in children

*"...corroborates the original work... showing effectiveness and safety of stannous fluoride used in an abrasive-compatible dentifrice..."*[1]

## PREVIOUS CLINICAL STUDIES

the original series of Crest clinical studies showed equally significant results ...

*Clinical Study No. 1*

REPORTED FEBRUARY, 1955, THE JOURNAL OF THE AMERICAN DENTAL ASSOCIATION

Results: 49.3% caries reduction in children[2]

*Clinical Study No. 2*

REPORTED NOVEMBER, 1955, THE JOURNAL OF THE AMERICAN DENTAL ASSOCIATION

Results: 36% caries reduction in children[3]

*Clinical Study No. 3*

REPORTED FEBRUARY, 1956, THE JOURNAL OF DENTAL RESEARCH

Results: 41.6% caries reduction in adults[4]

## PRESCRIBE CREST

CREST is the only stannous fluoride dentifrice . . . the only dentifrice that can give to your patients the protection against caries so clearly demonstrated in the above studies.

**PROCTER & GAMBLE**
*Division of Dental Research*
*Cincinnati 1, Ohio*


*FLUORISTAN is Procter & Gamble's registered trademark for an exclusive combination of stannous fluoride and a fluoride-compatible polishing agent*

1. Jordan, W. A. and Peterson, J. K.: Caries-inhibiting value of a dentifrice containing stannous fluoride: first year report of a supervised toothbrushing study. J.A.D.A. 54:589 May 1957. 2. Muhler, J. C., Radike, A. W., Nebergall, W. H. and Day, H. G.: Effect of a stannous fluoride-containing dentifrice on caries reduction in children. II—Caries experience after one year. J.A.D.A. 50:163 Feb. 1955. 3. Muhler, J. C., Radike, A. W., Nebergall, W. H. and Day, H G.: Comparison between the anticariogenic effects of dentifrices containing stannous fluoride and sodium fluoride. J.A.D.A. 51:556 Nov. 1955. 4. Muhler, J. C., Radike, A. W., Nebergall, W. H. and Day, H. G.: Effect of a stannous fluoride-containing dentifrice on dental caries in adults. J.D.Res. 35:49 Feb. 1956.


# Paste Tablets Pumice
# TAKE YOUR CHOICE for BETTER PROPHYLAXIS

Buffalo Dental Flour of Pumice, Pumice Tablets and Prophylaxis Paste have one big point in common. All are made from pumice that's imported from the island of Lipari, Italy—undisputed sole source of the purest, highest quality pumice in the world—the one pumice best suited for dental prophylaxis.

You can thus be sure of uniformly fine, cleaning properties of any of these Buffalo prophylaxis products. They insure results that you and your patients will like. But don't risk disappointment by accepting substitutes. Insist on genuine Buffalo Dental Flour of Pumice, Tablets or Paste.

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*AT YOUR DENTAL DEALER*

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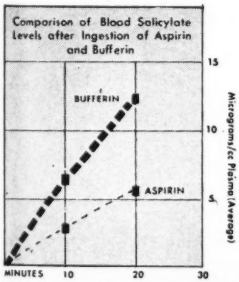


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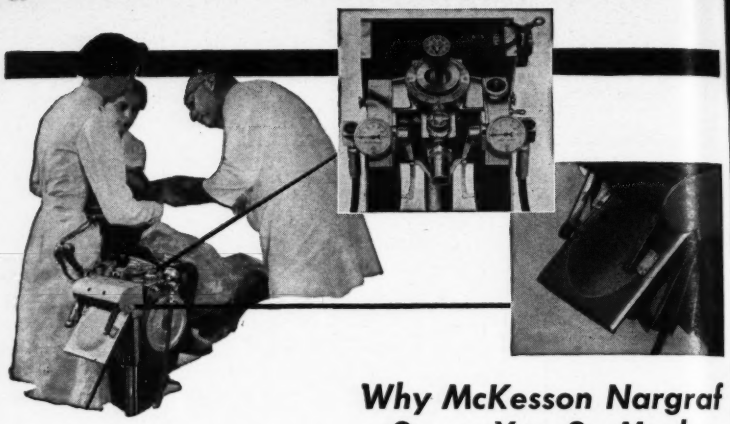

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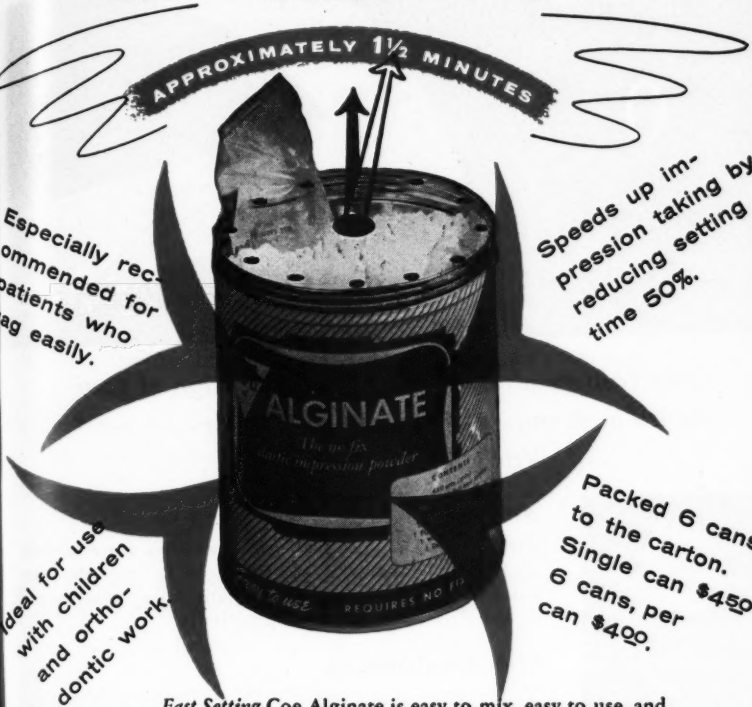


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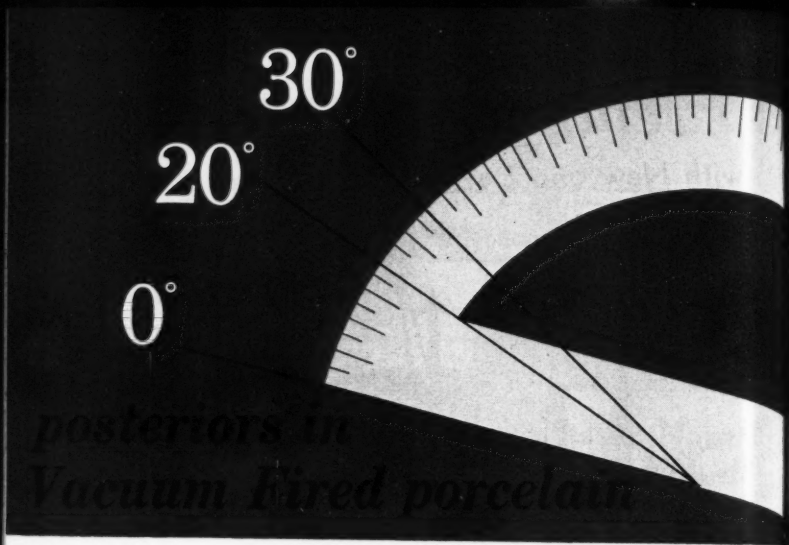


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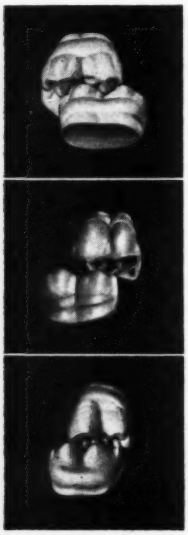

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EDITOR
EDWARD J. RYAN
BS, DDS

ASSOCIATE EDITOR
MARCELLA HURLEY
BA

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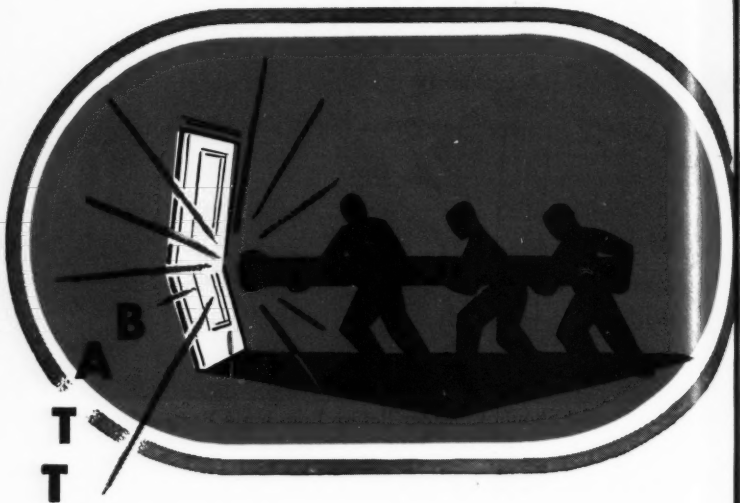

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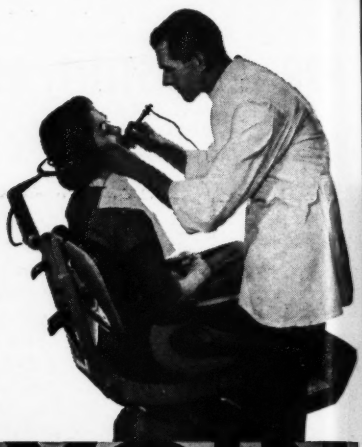

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# *Picture of the Month*


DOCTOR Wendell Cox; Justice Talbot Smith, of the Michigan Supreme Court; and Doctor Haley Bell, are shown celebrating the opening of radio station WCHB at Inkster, Michigan. Justice Smith represented Governor G. Mennen Williams at the open-house festivities attended by some 5000 well-wishers. The station is owned by Doctor Bell and his son-in-law, Doctor Cox. *Photograph courtesy of Jet Magazine, Chicago.*

*Ten dollars will be paid for the picture submitted and used in this department each month. Send glossy prints with return postage to* ORAL HYGIENE, 708 *Church Street, Evanston, Illinois.*

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IN 2410

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# These Emergency Calls!

IN 2410

IN 2410

IN 2410

IN 2410

IN 2410

IN 2410

**By GEORGE A. PEREIRA, BS, DDS**

THIRTY patients in nine hours—this was a full, busy Friday, and I returned home with the pleasant prospect of a quiet, relaxing evening. I noticed that my wife had cleaned the window screens and they were ready to be put up. This job, I decided, can wait until tomorrow afternoon, when I will feel more energetic.

At 9 PM I was comfortably settled in my easy chair, glancing through the latest fishing magazine, and enjoying the agreeable afterglow of an excellent dinner, when I was disturbed by the insistent ring of that good-evil invention, the telephone. With the usual question in mind, I picked up the receiver.

"Doctor Pereira?" a feminine voice inquired.

"Yes."

"My 16-year-old son is having terrible pain from a tooth. We can't contact our family dentist, and

***Our code of ethics demands that we give emergency service, and the treatment must be of the same standard as provided during office hours.***

have tried a number of others without success. Will you tell me what we can do so he can get some sleep tonight?"

Mentally I gave her credit for a pleasant voice, a real reason for calling, and the uncommon good sense not to wait until 3 or 4 AM "How soon can you be at my office?" I gave her the address.

"In about 15 or 20 minutes."

"All right, I'll see you there."

In the office, examination showed that the lower left first and second molars were causing the pain. The crowns of both were completely decayed away to the

gingival line. The only times the patient had been in a dental office before were to have two other molars extracted—both emergency calls. I extracted the two teeth for him, meanwhile trying to emphasize the importance of regular visits to the dentist and restoration of his teeth. I suggested that he call the family dentist the following day for an appointment and complete oral examination. However, I doubt if my words had much effect, and perhaps sometime in the future when I am trying to relax after a busy day in my office I shall receive another emergency call from this family.

Five minutes after I returned home, I received another emergency call. A patient of mine for whom I was doing extensive dentistry was having some discomfort, but could control it with aspirin overnight. Could he come in to my office in the morning? Although I knew that I had about a dozen patients booked between 8 AM and noon Saturday morning, I told him to come in and I would do what I could for him.

Saturday morning during office hours I received two more emergency calls, and one person came into the office without an appointment. Of these three, only one was a former patient. I treated all of them, thereby closing my office hours after 1 PM instead of at noon.

This number of emergency calls within such a short period of time is unusual, but they do seem to come in bunches.

### Combines Office and Home

Recently, while attending a dental convention, a young dentist mentioned to me that he was having built a combination home and office. I asked whether he thought he would have more emergency calls when his office was combined with his home. He stated that he did not have many emergency calls, and when he received one he would prefer to step into his office than to get out his car and drive to the office. Another young dentist nearby suggested that he did not have to answer his 'phone, or his wife could say that he was not in. The second dentist also stated that 95 per cent of emergency calls were from persons who were neglectful, and would never be satisfactory dental patients.

I mention this incident to illustrate various attitudes of members of our profession toward emergency calls. Since dentists vary in their convictions, from those who never treat an emergency case outside of office hours, to those who answer every emergency call at any time of night or day, I believe that we can all benefit from a general appraisal of this subject.

First, let us consider our code of ethics in relation to emergency calls. I quote the following statements from the PRINCIPLES OF ETHICS published by the American Dental Association:

"The maintenance and enrichment of this heritage of professional status place on everyone who practices dentistry an obligation which should be willingly accepted and willingly fulfilled . . . there is no alternative for the professional man in that he must place first his service to the public. The dentist's primary duty of serving the public is discharged by giving the highest type of service of which he is capable, and by avoiding any conduct which leads to a lowering of esteem of the profession of which he is a member. The dentist has an obligation when consulted in an emergency by the patient of another dentist to attend to the conditions leading to the emergency; and to refer the patient to his regular dentist, who should be informed of the conditions found and treated."

I am sure that every member of our profession has read the above statements before. However, experience has led me to believe that some dentists have forgotten them, ignore them, or take them lightly.

How can any dentist, with clear conscience and these principles of ethics in mind, refuse to answer his telephone for fear that it may be an emergency call; or have his wife answer that he is not available, when he is? This is a flagrant violation of the principle that he must place service to the public before financial gain, personal comfort, or convenience. This conduct also leads to a lowering of esteem of the profession at a time when we can little afford this—when unethical laboratories are encroaching upon our services, and socialized dentistry is a constant threat. The people who have difficulty obtaining emergency service will be in the vanguard of those crying for government control over dentistry, or praising the denture service of unethical laboratories. If so, the blame will be ours.

### Unethical Excuses

In these prosperous days, when the public is educated to the benefits of dentistry and the standard of living is high, excuses for unethical conduct come easily to us: "I'm doing enough service for my community," "It's his own neglectful fault he's having trouble," "Let him call some other dentist who isn't so tired or needs the patient more." These rationalizations can go on until our ethical conscience is salved, in fact, almost nonexistent. Once the professional conscience has been eased in this way, the next step can reasonably be inferior services for higher fees, and further detriment to our profession.

I believe we have established that the dentist cannot refuse to provide emergency service, unless he is able to refer the patient to another dentist who can furnish the same standard of treatment. I shall merely enumerate some of our other obligations related to emergency calls.

The service must be of the same

standard provided during office hours. Taking and developing an x-ray cannot be neglected because the dentist is in a hurry. Proper care should be taken, and post-operative instructions given to the patient. Perhaps the patient will not be an emergency case again if time is utilized to educate him regarding the benefits of regular dental care and new methods which allay fear. If the patient has been to another dentist, he should be referred back, and the dentist informed of the conditions found and treated.

Of course, emergency service should not be free service. If the fee is the same as that charged during office hours, the patient will have no financial inducement to appear for regular appointments. Since fees are variable according to the individual dentist, service, patient, and community, my opinion is that the emergency fee should be 1½ to 2 times the usual fee charged a patient for the same appointment service.

If a dentist who is disturbed by the number of emergency calls he receives and is encouraged by these thoughts to continue treating all of them, I will feel that my effort has been successful. Let us have empathy as well as sympathy for the emergency patient; that is, the ability to put ourselves in the other person's shoes. Ours is not the obligation to judge the emergency case, but to treat it.

323 *Appleton Street*
*Holyoke, Massachusetts*

## THE COVER

THIS MONTH'S cover photograph of the Manitou and Pike's Peak Cog Railway train on the way to the summit of Pikes Peak, represents an invitation to the annual meeting of the Colorado State Dental Society, which will be held at The Broadmoor, Colorado Springs, from October 6 to 9. Each "train" consists of one diesel-electric locomotive and one plexiglass paneled ceiling coach—more than one coach would buckle the train on the steep grades. For reservations and information about the meeting please write to Doctor G. H. Jackson, Secretary, 724 Republic Building, Denver.

## WHEN YOU CHANGE YOUR ADDRESS

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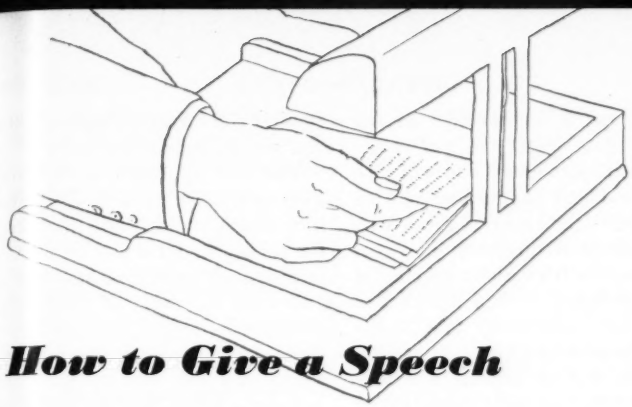


# How to Give a Speech

**BY L. A. KEATING**

***A few suggestions on how to overcome nervousness and hold the attention of your audience.***

"ANYONE can give a good speech who wants to and who has something to say," declares Professor Lynn Surles, director of Business and Professional Speaking at Marquette University, Milwaukee. Therefore, unaccustomed to public speaking as you probably are, if you will make use of a few basic techniques you can acquit yourself well next time you have to "talk on your feet."

You will be nervous, of course. Even speakers of long experience perspire and fidget before they get under way. But the more you prepare, the less nervous you will be. Too, there are ways to combat nervousness.

"First, understand it," urges Professor Surles. "It is Nature's way of keying you up to meet a challenge. You can get the upper hand on nervousness in two ways: by relaxation, and by taking plenty of time.

"There is a psychologic help, too. While the chairman is introducing you and you wish you were home in bed, say to yourself, 'Well, they're asking for this, so let the audience be nervous.' "

When your name is called, rise from your place as relaxed as possible. Take plenty of time. On the platform, as you look over the audience, think about relaxing—your neck, your shoulders, your arms. See to it that your hands are limp on the podium. *Stand there taking plenty of time.* Your audience will wait. As you realize how patient they are, you gain confidence. Confidence erases tension.

Sure you are ready now to begin? State your opening line and pause. Say another line. Pause. Look around. These pauses will calm you, and they effectively grip your hearers' attention. Actually,

the pause is as effective as the words you speak. As you make successive statements you will pick up speed and confidence; and as you notice the attention given you, nervousness is forgotten.

Here is a trick about looking at your audience. It is distracting to pick out individuals and watch their faces to see how you are doing. Do not see anyone individually. While you talk, slowly sweep your gaze along the last two rows of the audience from one side of the hall to the other. Then slowly sweep back. Keep doing this, and every person facing you will believe you are looking at him.

Start in low gear, offering earnestness and sincerity. Your enthusiasm will rise and carry you to the needed heights in good time. Remember, you make the greatest impact with earnest understatement followed by a pause. Never yield to excited exaggeration.

Gestures? Do not force them, experiment, or imitate. Just do what comes naturally.

**Never Read a Speech**

Now let us go back to preparation of your speech—because an audience worth talking to is worth doing your best for. Never read your speech—that puts people to sleep. Of course, you may have to read brief technical passages or quotations; but reading takes your attention away from your listeners. Never memorize your speech, because if you forget a couple of lines you may be headed for disaster.

The best approach is to know *what* you want to say. When the time comes, you will find the words for saying it. Jot down on a card or a sheet of paper the list of topics you want to cover. Be sure their sequence is logical and effective. Place your card on the podium where you can see it, but your audience cannot. Discuss your first subject and stop. Take up the next item. When you have discussed your final point, wait four or five seconds, then leave the podium.

What if someone heckles you? It is risky to attempt matching wits with a heckler; you may lose and look foolish. Instead, take a step or two his way and gaze at him in silence. Then turn back and resume your talk.

"Use all the anecdotes you can to illustrate the points you wish to make," Professor Surles advises. "Anecdotes reveal people in situations, and audiences love them. Seventy per cent example material and 30 per cent of your own opinions will hold listener interest. Later, people will forget your opinions, but remember your anecdotes. Get used to saying, 'When this point came up at another meeting . . .,' or 'Let me illustrate with an experience I had.' "

To sum up: prepare your speech by making a list of subjects you can jot down on a small card. If possible, give the speech aloud

once or twice to an empty room. When the chairman introduces you, fight nervousness with deliberation. Speak slowly, with frequent pauses. Look at the mass of faces, never at individuals. When you finish what you planned, do not repeat or add something new on impulse. Wait a few seconds, then return to your seat.

**Your Success Formula**

Should you be called on with little warning, use this three-point formula, which is reliable if you know your field:

1. Stand up, relaxed, and say, "Gentlemen, here is how this matter seems to me." Or, "Here is the point I wish to make." State in one sentence, or as concisely as possible, the idea you wish to put across.

2. Next say, "Let me give you an example." Relate an apt anecdote in your best story-telling manner. Give names to your characters. Quote them. Keep it brief.

3. Lastly say, "Here is what I believe we should do." State your proposal in simple terms. Remain standing three or four seconds; the silence will help drive your points home. Go back to your seat.

Or say you are called on unexpectedly, and are puzzled what to tell this group. In the few moments you have to think, ask yourself: How can I help them? The answer is what you should talk about.

So, next time you hear a chairman say those fateful words, "It now gives me great pleasure to introduce . . ." and he mentions your name, why worry about being nervous? It is as inevitable as taxes. But you can control it by trying to relax, and above all, by taking—plenty—of—time.

Remember, these folks must want you to talk. They are asking you to, aren't they?

210 *East Michigan Street*
*Milwaukee 2, Wisconsin*

## CARE OF TEETH DURING PREGNANCY

THE OLD saying, "For every child a tooth," is based upon the belief that the fetus takes calcium from the mother's teeth. Although modern investigation refutes this contention, there is no doubt that some women do suffer markedly from dental decay during pregnancy. Accordingly, the dentist should be consulted early and his recommendations followed. The old notion that dental treatment causes miscarriage is without basis. On the contrary, a thorough overhauling of the teeth is a good preventive measure against this and other accidents of pregnancy; extractions are preferably done under local anesthesia. Meanwhile assiduous care should be used in cleansing the teeth after meals and in the use of an alkaline mouthwash night and morning.—NICHOLSON J. EASTMAN, MD, *Expectant Motherhood*, ed. 3, Boston, Little, Brown and Company 1940.

# Fundamentals in the Medication of Dental Patients

BY R. S. PING, DDS*

THE *diagnosis* comes *first* in the treatment of any disease, then the decision by the practitioner regarding what drug should be administered to bring about the desired results in the patient.

Drugs are used in dentistry:

1. As an aid in diagnosis: for example, lipiodol in roentgenography, or the use of a local anesthetic to prove or disprove a suspected area as the etiologic factor of pain.

2. To prevent certain complications or extensions of disease, such as, the use of antibiotics in patients having had rheumatic fever—to prevent a subacute bacterial endocarditis. Drugs are frequently used to reduce the possibilities of the various phlegmons from occurring following surgical procedures in the oral cavity. Extension of a high anterior facial cellulitis might involve the cavernous sinus, so drugs are employed here more routinely than might otherwise be necessary.

3. For the alleviation of symptoms of disease.

4. As adjuvants in the cure of disease. Unlike the physician, there are only a few diseases of dental origin that the dentist can cure with drugs alone. Generally speaking, drugs can but assist, and specific dental treatment is necessary to effect a complete cure. An example is the use of drugs to control an acute infection to the point at which endodontic, periodontic, or

*Doctor Ping, Associate Professor of Oral Surgery, Indiana University School of Dentistry, and Consultant in Dentistry for Eli Lilly and Company, presented this paper at a Symposium on "Medications in Dentistry," held at Indiana University School of Dentistry.

***In the use of medication in the dental office the fundamentals must be established to enable dentists to use drugs properly.***

surgical treatment can be undertaken successfully.

In summarizing the fundamentals of using drugs in dentistry: the pharmacodynamics of each classification should be considered. A patient experiencing pain should receive an analgesic, given systemically; an anodyne, applied locally; or both. All patients interpret discomfort in different ways and degrees (modified by the cause).

One patient will need only a mild acting analgesic, one will require treatment for moderate severe pain, while still others must have a drug for severe pain. An antipyretic will do nothing to reduce a normal temperature, but will act to lower febrile temperatures. A patient sleeping well, regularly at night, requires no assistance from hypnotic drugs; but the same individual could well use a drug to enhance sleeping, should he have to sleep days instead of the hours he is accustomed to. All patients can well use mild sedative or tranquilizing drugs prior to dental operations, but only the patient with manifest nervousness should require more potent drugs for the same result.

These uses are mentioned to start a chain of review of all of the variations and effects possible when using drugs—which is a constant challenge to all dentists.

In order to *secure success* with a drug, the remedy must be *properly indicated*, the preparations selected must be *active*, and an *effective therapeutic* dose must be administered. Also of prime importance in the use of medicine is weighing the *hazards* of the *drug* against the *hazards* of the *disease*, using only drugs judged to be the less hazardous. The dentist *should know*, in *advance*, what symptoms may appear in case of toxic action, and be prepared to treat them promptly, *thus avoiding* morbid incidents.

The necessary information for each drug to be used can be catalogued as follows:

1. Indications for this classification of drug. (For example, for pain use analgesic.)
2. Name of drug, preparations available, the active constituents, and the source of information.
3. When and when not to use the drug, and when to discontinue it.
4. Dose, regularity of the dose, conditions modifying the dosage, and the best route of administration.
5. How the drug acts, and how to evaluate that action.
6. Toxicology: Symptoms of poisoning; treatment of poisoning.
7. How to order: Solubilities and

incompatibilities. Write correct prescriptions using Metric or Apothecaries' weights, English in the inscription, Latin contractions (abbreviations) in the subscription and signature. Avoid personal abbreviations, but use clear and precise statements. Use English longhand if no official abbreviation is known.

## PAYING FOR BROKEN APPOINTMENTS

A LETTER addressed to the legal department of *The Evening Bulletin*, Philadelphia, Pennsylvania, and the answer will interest all dentists:

Dear Philadelphia Lawyer: I recently had an appointment with a dentist for 2:30 one afternoon. About 10.30 that morning my car broke down, so I called his office to say that I would be unable to keep the appointment. The dentist incidentally was located in another town. His secretary said that the dentist would not like this at all, that he must have 24 hours' notice if an appointment could not be kept. They would let it pass this time, she said, but if it happened again there would be a charge for the time he allotted me. Can a dentist or physician collect for a broken appointment under these circumstances?—H.S.

He certainly can. Abraham Lincoln once said that a lawyer's time and knowledge are his stock in trade. They are what he has to sell. The same thing is true of both physician and dentist. When the dentist set that hour aside for you he foreclosed himself from seeing anyone else during that time. Pecuniarily, therefore, your cancellation caused him a loss. Now, you may not realize it, but your calling to make an appointment and having a time set for your appointment with the dentist constituted a legal contract. As the Philadelphia Lawyer has said so often, a contract is like a two-way street; it runs in both directions. Consequently, if one party to a contract rescinds the same unilaterally, he may become liable to the other party for whatever damages the rescision may cause. In this case, the damages would be the dentist's potential earnings during the hour he lost because you could not get there on time. Under these circumstances it would be quite proper (and also legal) for the dentist to bill you for the unkept appointment.

# So You Know Something About DENTISTRY!

BY ROLLAND C. BILLETER, DDS

## CLV

1. A (a) low, (b) high, temperature wax elimination produces castings with desirable smooth surfaces. _____

2. True or false? The temporomandibular articulation is the only bilateral joint in the human skeleton. _____

3. The setting time of zinc oxide-eugenol cements may be (a) increased, (b) unchanged, (c) decreased, by the addition of various metallic salts. _____

4. In replanting a tooth, approximately how much of the apical portion of the root should be removed? _____

5. Processing a self-curing resin at higher than room temperature (a) decreases, (b) increases, the strength slightly. _____

6. Does the removal of teeth usually have any effect in relieving the pain of trigeminal neuralgia? _____

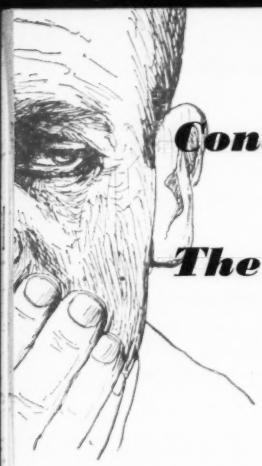
7. What is the greatest danger accompanying anesthesia? _____

8. True or false? The full porcelain crown is contraindicated in patients who have a deep overbite and little or no overjet in the anterior region of the mouth. _____

9. Excementosis results from (a) low grade infection, (b) traumatic stress. _____

10. What bones constitute the hard palate? _____

FOR CORRECT ANSWERS SEE PAGES 66-68



# Consultation Clinic:

# The Dolorogenic Denture

BY ARTHUR ELFENBAUM, BA, DDS*

A DOLOROGENIC denture is one that causes pain. There is nothing unusual about that. The dentist asks the patient where it hurts, he looks for the telltale lesion, and adjusts the denture—but that is too simple a theme for a dental journal. Few things can be more aggravating, time-consuming, and frustrating than to have a patient interrupt a busy dentist in the middle of a one-hour appointment with the complaint that the new dentures delivered the day before look beautiful, but they hurt too much. Then, when the dentist examines the mouth, there is no lesion to be seen. Neither the patient nor the dentist can identify the sore spot, and a roentgenogram sheds no further light on the matter. It would be well for the practitioner to consider some of the following possibilities for such aggravating circumstances.

In some mouths the palatine foramina can be located by corresponding shallow depressions in the mucosa. The palatal surface of an impression for a complete upper denture clearly shows little mounds corresponding to these depressions. Unless the elevations in the impression, or the depressions in the model are leveled off, the impingement of the finished denture can exert pressure on the nerves entering the foramina, and cause constant pain without any observable lesion. Before the impression is taken, the foramina should be located with the finger. If the cause of the pain is discovered after the denture is completed, the small elevations can still be reduced, but the dentist must first recognize them as etiologic factors in nerve impingement.

When the anterior bony ridge of either arch becomes severely re-

*Professor of Diagnosis and Chairman of the Department at Northwestern University Dental School, and Consultant in Diagnosis at the Dental Training Center of the West Side Veterans Administration Hospital in Chicago.

***Here are some possibilities to consider when the denture produces pain and the cause is evasive.***

sorbed, the mucosa covering it is often found to be hyperplastic. The resorption may be a sequence of a former periodontal disease, or of the pounding of the six lower anterior teeth against a complete upper denture without benefit of a partial lower denture. The condition is also frequently encountered under old dentures which have been worn for many years without proper adjustment. The flabby tissue becomes macerated under the denture, and painful areas develop in the soft tissues and in the underlying bone. To correct the condition, the dentist would do well to take the denture away from the patient for a week to relieve the pressure on the crowded tissue and let it find its own level, so to speak. It becomes relaxed and redistributes itself over the bone. In many cases the mucosal covering then becomes so equalized in consistency and thickness, that surgery is obviated. If, after the week, some excessive mucosal hyperplasia is still present, surgery is then indicated, but much less than if the loose tissue had been reduced immediately. If the hyperplastic tissue is not reduced or allowed to redistribute itself, and the patient is permitted to use the old denture until its replacement is completed, the new denture cannot be expected to fit any better than the old one.

When compound is used for a preliminary or "snap" impression, flabby tissue is easily distorted. The "wash" in the compound impression or in the tray made from it, does not compensate for the pressure exerted by the compound, and the completed denture cannot improve on the impression from which it was made.

**Recall System Imperative**

The importance of a recall system for denture patients cannot be too strongly emphasized, especially for those who lost their teeth because of periodontal disease. Relines, resets, or remakes can rehabilitate the mouth. If, before the teeth are extracted, the dentist prepares the patient psychologically for possible and probable adjustments, there will be no misunderstanding at a later date when an extra fee is quoted for the corrections.

A common complaint by denture patients is that they experience pain in the lower ridge when they bite into a sandwich, yet the dentist is positive that the denture was constructed perfectly. To reassure himself that he did not overlook a thing, roentgenograms of the mandible are taken, and it is found that the bony ridge shows a definite cortical line. Hence, the patient must be mistaken, or, let us say, touchy. However, despite the negative film, the dentist may be in

error. The true cause of the patient's discomfort may be a ragged or knife-edge crest on the bony ridge. It was not seen in the film because the exposure was excessive for the thin bone, and actually "burned out" the image. The treatment indicated in such a case is a little extra relief on the inner surface of the denture where it rests on the painful ridge, or the bone must be reduced surgically.

In patients with a history of severe periodontal disease and excessive alveolar bone resorption following the extraction of the teeth, two painful spots sometimes occur under the mandibular denture in the bicuspid areas, but there is no lesion to be seen. In a normal dentulous mouth the mental foramen is located half-way, more or less, between the alveolar crest and the lower border of the mandible; but when severe resorption follows the extraction of periodontally diseased teeth, the residual ridge may recede down to the level of the mental foramen. The denture then rests directly on the foramen, and is separated from the nerve by only a thin mucosa, causing pressure pain. Digital examination before the impression is taken for the denture can often locate the foramen, and the impression, model, or finished denture can be adjusted accordingly. An occlusal roentgenogram may also help identify the foramen.

Pain in the mandibular anterior ridge under a denture sometimes defies diagnosis. No sore is visible and the roentgenogram is definitely negative despite reduced exposure time. If the ridge is thin, its counterpart on the model may have been broken or abraded in handling in the laboratory. Occasionally the ridge on the model is broken away when pressure is applied during the trial packing of a hardening acrylic dough. The crumbs broken off the model are displaced, and the inside of the finished denture in the ridge area is not true. The discrepancy may permit the seating of the denture, but it may defy detection and induce pain.

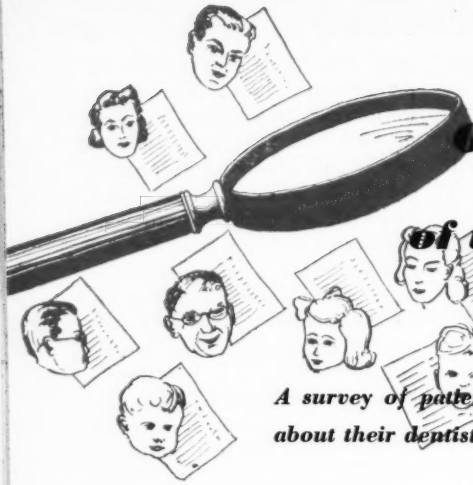
If the tuberosity or the incisive papilla is injured in handling the maxillary model, the corresponding areas in the denture cause discomfort. Many dentists make it a practice to shave away some of the labial and buccal surfaces of the upper model to make the denture fit tighter, but the bone may resorb in response to the pressure. The denture that had to be blown off the maxilla soon becomes loose. Similar circumstances arise when a postdam is cut into a maxillary model without considering that the mucosa covering the bone in the midline is much thinner than the resilient tissues on either side of it. The postdam should be made by the dentist and not by the laboratory technician, but only after he has made a thorough study of the resiliency of the tissues with his fingers.

Symptoms of pain without ac-

companying signs are occasionally encountered when one tooth in an artificial denture comes into premature contact with an opposing tooth. When this occurs in a natural dentition, it could possibly initiate a periodontal disturbance, but in a denture the extra strain exerted on the extruded tooth may be transmitted to and through the opposing denture to the mucosa in line with it. Sometimes the stress is transferred along the denture to another part of the denture-bearing areas, causing a sore spot for which it is difficult to account. To give the patient relief, the denture base at the site of the pain should not be relieved. The extruded tooth which is causing the pain must first be identified, and then reduced (it may have moved in the wax try-in or during the processing). One should remember that in reducing teeth or base material in a dolorogenic denture, the correction must not be made radically. An excessive amount of reduction may spoil the occlusion or the fit of the base. When the patient states that the correction has eased the pain, allowance should be made for the healing of the tissues following the relief. It could be extremely disturbing to have a patient return saying the pain has disappeared, but now the food packs in under the denture where it was ground.

Perhaps the most pathetic figure who consults the dentist for pain under a denture without apparent cause is the lonesome, world-weary, aged patient in search of what has been aptly called a psychologic anchor or therapeutic crutch. In addition to his social, financial, and emotional problems, he may be suffering from the oral manifestations of the postclimacteric period. Nutritional deficiencies may be responsible for a painful burning tongue. Someone has probably suggested to him that he is allergic to the acrylic in his dentures, and the dentist becomes involved. He recalls that before his dentures were made, the dentist listened patiently to his dental and medical experiences—why not visit him again, tell him about his sore mouth, and at the same time unburden himself of his other troubles? A little grinding of the denture or just a touch of medicine on the sore spot is all he requests, and he knows the dentist would not begrudge him a few moments between appointments. Actually the patient is hungry for some reassurance to restore his self-confidence. There is a place for such psychotherapy in the dental office; it is beneficial to the patient, and helps the dentist build a practice. If a patient can find solace through an occasional "free" visit to the dentist's office, could you be courageous or cruel enough to dismiss him? I could not.

431 *Oakdale Avenue*
*Chicago* 14, *Illinois*



# Get the Views of the Patients!

BY CHARLES L. LAPP, PhD*

***A survey of patients who tell how they feel about their dentist.***

*Question No. 1: Do you have any gripes about dentists you have gone to?*

| | |
|---|---|
| Yes | 56.8% |
| No | 40.2% |
| No Answer | 3.0% |

*Question No. 2: Have you ever had poor dental service from a dentist?*

| | |
|---|---|
| Yes | 55% |
| No | 45% |

*If yes, please cite what you feel to be poor dental service.*

While cleaning my teeth he cut my mouth.

Failed to take all the decay out of a tooth, and later had to have it redrilled.

Didn't clean my teeth properly, which led to bleeding of my "gums."

Takes too long to get an appointment with a dentist.

Didn't take x-rays before doing my dental work.

Let drill slip into my cheek.

Was awkward in pulling a tooth.

Had a recurrence of the same trouble I went to the dentist originally to have taken care of.

Did a poor job of cleaning my teeth.

Different dentists find different things wrong.

Have to go back too often for short appointments.

*Doctor Lapp is Professor of Marketing at Washington University, St. Louis, and a management consultant, and author of the book, "Successful Selling Strategies," McGraw Hill Book Company, New York, 1957.

Found cavities other dentists didn't find.
Pulled the wrong tooth.
Pulled a tooth which could have been saved.
Broke a tooth when pulling another tooth.
Jacket the dentist put on came off in six months.
Left part of a tooth in the "gum" when making an extraction.
Had to extract a tooth in pieces because of clumsiness.
Not really interested in you as a patient—just your money.
Made a bridge which didn't fit.
"False" teeth broke in two.
"Filling" stayed in only a short time.
Poor matching of enamel silicate.
Wanted braces, but dentist said I didn't need them. Then the next dentist I went to thought I should have worn braces, but pointed out it was now too late.
Met a few who should still be in school.
Some don't believe in pain-killing drugs.
Cavity deeper than the dentist thought it was.
Pulled a tooth without taking an x-ray.
Handle you too roughly.

*Question No. 3: How do you feel about the fees charged by dentists?*

| | |
|---|---|
| Too High | 59% |
| About Right | 39% |
| Too Low | 2% |

*Comments:*

Concerned mainly with getting as much money as they can.
Just too high on some of their services.
Don't know, and don't feel I can be a fair judge.
Depends on the service they give.
Some are too high—some too low—few about right.
Must be too high, because they don't tell you for what their charges are made.
Charge different patients different amounts—seem to try to charge all they think a patient will pay.
Have no idea what dental charges are, because I go to the dentist so infrequently.
Some seem to be far more expensive than others for no good reason.

*Question No. 4: Do you feel your dentist does more than necessary to keep your teeth in good condition?*

| | |
|---|---|
| Yes | 26% |
| Sometimes | 19% |
| No | 55% |

*Comments:*

Try to get out of their patients all they can.
Calls you back for frequent check-ups.
Insists on always cleaning your teeth.
How should I know?
Requires too many visits for work done in order to charge you more
Takes a lot of time explaining how and why cavities are formed.
Takes time to recommend toothbrushes and mouthwashes.
Goes wild with his x-ray machine.
If my dentist had done more maybe my teeth would all still be in good condition.

*Question No. 5: Do you feel dentists conduct their practice on a business-like basis?*

| | |
|---|---|
| Yes | 88% |
| No | 12% |

*Comments:*

Dentists lose many patients because they get tired of waiting.
Statements on time, but they are always late for appointments.
Lose business by doing sloppy work.
Sometimes dentists become too personal in their conversations.
Poor business men—they need a good deal of training along this line.
Gets his bills all mixed up.
Too many leave all business aspects of their practice to their assistants and their accountant.
Never know what the cost will be until you get the bill.

*Question No. 6: When you have an appointment with a dentist do you have to wait?*

| | |
|---|---|
| Usually | 35% |
| Sometimes | 19% |
| Seldom | 30% |
| Never | 16% |

*Question No. 7: Please indicate any phrases that dentists may have used that are irritating to you.*

This needle will take away all the pain.
Open wide!
You need to come back more often.
Well! Let's have a look!
A little wider!
As I told you before—.
Now, that didn't hurt, did it?
Just sit still!
This may hurt a little!

Just relax!
This won't take long.
Does that hurt?
I won't hurt you.
You don't have to pay me all at once—I can arrange for a loan or time payments for you.
Oh, your teeth look so nice!
Only have open ———— on ———— for an appointment.
I didn't feel a thing, why should you complain?
How's school? Your wife? Or your husband?
This hurts me more than it does you.
You are going to feel much better when it is over.
Come in more often.
Don't act like a baby!
Well! Well! We will have to get out that rotten snag!

*Question No. 8: Please indicate any mannerisms that dentists may persist in that are annoying to you.*

Leaning on you while he works.
Chewing gum.
Asking you questions when your mouth is filled and you can't answer.
Snapping fingers in time with the music.
Picks up and puts down an instrument again and again without using it.

Now that you have read the report of two hundred patients concerning their points of view regarding their relationship with dentists, you may find it profitable to reread the article and check those items about which you feel you should do something. Then ask your assistant or wife to read this same article, and get their opinion as to what mistakes, if any, you might be making in your patient relationships.

*Washington University*
*St. Louis* 5, *Missouri*

## FORMULA FOR LONGEVITY

SOVIET scientists have now discovered the long sought formula for longevity. Certain to be unpopular with advocates of a shorter work week, the formula is "constant, and sometimes, quite tense work, often continuing almost right up until death." It was based on an extensive study of 10,000 men and women 90 and more years old. The study also produced a rebuttal of the theory that people who live in the mountains live a long time.—*Medical Science, Philadelphia.*

# What the Dentist Should Consider Before Entering a Partnership

BY WILLIAM H. ALLEN, JR, LLB

NOT LONG ago there came to my attention a dental partnership that had gone on the rocks and dissolved. It had done so because it did not have a sound foundation in business principles. Like so many partnerships, its only basis was the friendship of the individual partners. Now certainly the partners must get along with each other, and must be friends if the partnership is to last; but if friendship is the *only* basis then the partnership is doomed from the beginning.

In order to last, a partnership must be advantageous from a business point of view, to the individual partners. There may be a number of reasons why a partnership may be advantageous for all concerned.

First of all, it may considerably decrease the overhead of all of the several partners. In many cases office expense, such as salaries, rent, telephone, utilities, stationery, postage, equipment, and supplies, can be considerably reduced by entering a partnership.

Another advantage that a partnership may have over individual dental practice is that it may make it possible to unite in one office dentists of varying knowledge, skills, training, specialties, and experience. This in return may enable the partnership to render a wider range of service, and may thereby increase the practice of the partnership more than simply from a combination of the efforts of the individual partners. Partnership may make possible a division of labor among the partners, as in a dental clinic.

***Is a partnership to your advantage, and what provisions should govern it?***

There may be other reasons why a partnership may be advantageous to you. Before you enter a partnership you should be sure it is to *your* advantage to enter it; otherwise you may find that a partnership can cost you a good deal in money and time, as well as in friendship and good will.

After you have decided that it is to your advantage to enter a partnership, you should come to a definite agreement concerning all phases of the partnership business with your prospective partners. This agreement should be reduced to writing so that it can be a guide which may be referred to from time to time as questions arise, or to settle differences that may arise among the partners. This agreement is called the articles of partnership.

The contents of your articles of partnership is something for you and your prospective partners to work out together. You know your business better than anyone else. You know what should be included in your articles of partnership. Generally speaking, however, there are certain provisions that may help to avoid misunderstandings and hard feelings later if they are agreed to at the outset. They are as follows:

1. Name and nature of partnership and names of partners.
2. Duration of the partnership —if this is not fixed, the partnership may be terminated at the will of any of the partners.
3. The capital of the partnership, and how it is to be contributed.
4. How the partners are to share in profits and losses.
5. Records and accounts to be kept, and method of accounting.
6. What bank shall be the depository of the partnership funds, and who will have the authority to sign checks in the partnership name.
7. Amounts the partners may draw from time to time, and amount of salaries.
8. Duties of partners in regard to the business side of the partnership.
9. Details of management of partnership affairs.
10. Retirement or expulsion of a partner.
11. Taking over the share of a deceased or outgoing partner.
12. A method for arbitration of any differences that might arise.
13. Dissolution of partnership on certain contingencies.
14. Method of winding up on dissolution.
15. Provide for partnership insurance.

Unless the provisions of your articles of partnership are going to be rather complicated, there is

no reason why you and your partner cannot agree on them and then write them down yourselves. They are a contract or agreement between yourselves. They need not be in any special form. They may be written, typed, or printed, or a combination of the three. You can use the list of provisions set out above as a guide and check list; then add anything else that is of importance to your particular business. If there is anything that you are in doubt about, or if you have any particular problems, I would suggest that you consult an attorney. His cost will not be much, and it will be money well spent; for it will save you money, friendship, and good will in the long run.

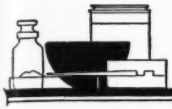
If you are contemplating entering a partnership be cautious. Make sure that it is to your advantage to do so, and then reduce your articles of partnership to writing. The trouble that it can save in the future is well worth the extra effort that it may take when you enter the partnership.

*Route* 1, *Box* 74*B*
*Tuscaloosa, Alabama*

## "WHAT EARLY MAN DISCOVERED ABOUT FOOD"

INSTINCT may play a part in animals' nutrition, but human beings acquired cultural patterns at an early stage. These patterns are ruthless. They have long since obscured the natural picture and made the operation of instinct improbable. They include taboos, religious ritual, educational programs, prejudice, even planned propaganda. All these, particularly in recent times, have blunted man's freedom of food choice and made it difficult to distinguish his original choices from mere social conventions. Yet there is inescapable evidence that primitive peoples chose their original diets shrewdly and with care—sometimes with more care than modern Westerners.

Perhaps today's nutritionist can learn as much by borrowing the methods of the anthropologist and studying man's food choices through the ages as he can in the laboratory. It may be that the Masai of East Africa, a tribe noted for exceptional physique, who live on milk, meat, and raw blood—or the splendidly healthy Hunzas of northern India, who for generations have eaten milk, butter, cereals, vegetables, fruit, and some goat meat—can teach as truly as laboratory-fed white rats.—WILLIAM H. ADOLPH, *What Early Man Discovered About Food, Harper's Magazine.*



# TECHNIQUE of the Month

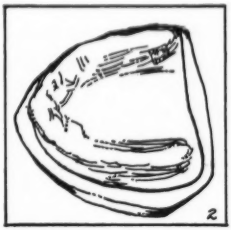
*Originated by W. EARLE CRAIG, DDS*

## Impression in Irreversible Hydrocolloid Over Modeling Compound Muscle-Trim

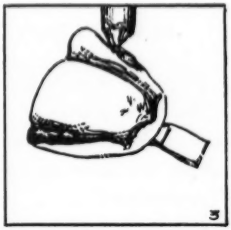
*By GEORGE VOGEL, DDS*

*Drawings by Dorothy Sterling*

Take impression in elastic impression cream. Pour model.

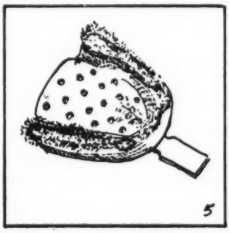


Adapt acrylic tray to model.

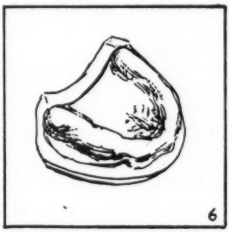


Muscle-trim peripheral borders with compound.

Heat compound. Dab absorbent cotton on compound for retention of irreversible hydrocolloid.

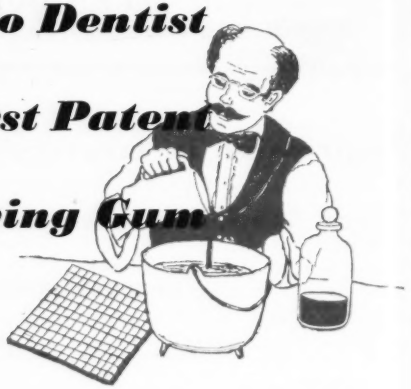


With #8 bur, drill holes in palatal area for further retention.



Take impression in irreversible hydrocolloid and pour up model.

# Ohio Dentist Secured First Patent on Chewing Gum



BY DANIEL FRANCIS CLANCY

***Pioneer developed gum to aid denture patients in late nineteenth century and was also the inventor of "first practical atomizer."***

AN EARLY Ohio dentist, the first American to patent chewing gum, Doctor William F. Semple of Mount Vernon, Ohio, also invented the so-called "first practical atomizer" in the late 1870s or early 1880s.

Sale of the atomizers was held up by the fact that Doctor Semple had also developed a medicine to be used in the sprayers, and refused to sell the atomizer without the medicine. It is reported that he eventually sold manufacturing rights.

Doctor Semple took out the first United States patent on chewing gum on December 28, 1869. His patent No. 98304 claimed the "combination of rubber with other articles, in any proportions adopted to the formation of an acceptable chewing gum." It was made in letter-size sheets about twice as thick as today's gum. Red and rubbery, it was perforated in one-inch squares, and had little flavor. It was a good deal tougher than present day gum.

Doctor Semple is thought to have conceived the idea for the gum from a rubbery substance used for making denture bases. It is believed he planned the gum for use only in aiding people exercising new artificial teeth, and as a tooth cleanser.

Many stories are told about Doctor Semple and his invention. One tale has it that a stranger came to

Mount Vernon, became a patient of Doctor Semple's, and in the process of having teeth treated managed to learn the secret of the dentist's discovery. The stranger then went east and manufactured the gum in flavored form.

Another tale is that a New Yorker came to Mount Vernon and offered Doctor Semple $20,000 for his gum secret. Doctor Semple said he would talk it over with his wife at lunch and give the man an answer that afternoon. He decided to take the offer. When he met the stranger, however, the man said he had just received a wire from New York saying the deal was off, and that his company had bought a better gum.

Chewing gum had been made and sold for some years, at least since 1848 in Maine. Doctor Semple was, however, the first to patent a gum.

Although Doctor Semple never managed to strike it rich, he was a figure of great interest and curiosity around Mount Vernon, and there was talk of several other "inventions" he had made, but no details of them are known.

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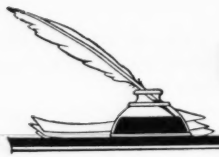
3. Stand at least five feet away from the patient and well away from the useful beam for all exposures. It is preferable to stand directly behind the tube head and at a distance of five feet. If this is impossible, a protective leaded shield should be used.
4. Only the patient should be in the direct path of the useful beam.
5. Complete blood examinations, every three months, are recommended for the personnel in a busy dental radiographic room.
6. Monitoring service is available and should be used in busy offices.

—WILLIAM E. KOCH, JR, DDS, *The Journal of the Missouri State Dental Association, March* 1957.



# EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

## *A RETIREMENT HOME FOR DENTISTS*

SEVENTEEN years ago ORAL HYGIENE assigned a special writer to prepare a series of articles on retirement homes for dentists. The articles appeared in the issues of January, February, March 1940.[1]

Although the response to this series was prompt, enthusiastic, and favorable, from dentists throughout the country, no action has been taken by any dental society to establish such homes for retired dentists.

In May 1957 the Iowa State Dental Society passed a resolution asking that the subject of retirement homes be considered by the House of Delegates of the American Dental Association at the Miami meeting in November. The idea is that such a home be established at the most favorable location in the country and that it be operated under the auspices of the American Dental Association for members, their wives or widows.

A retirement home is not a poorhouse or a domicile for the destitute. It is a place where dentists and their wives or widows may live in congenial surroundings, among their colleagues, in a favorable climate, and pay their own way at reasonable rates. For those who could not pay, money from the Relief Fund of the American Dental Association could be used without any kind of discrimination against such beneficiaries.

Most of the lodges, the larger trade unions, and church groups, have established such homes for retired members. There is one small retirement home in New York for physicians.

[1]Williams, Harriet: Dentists Grow Old Too, ORAL HYGIENE **30**:19, 164, 288 (January, February, March) 1940.

With the increasing number of aged in the population, there is more and more talk of the need for nursing and retirement homes. We may expect to hear more of these discussions. Some advocate that these homes be created by state and federal governments. Those who believe in free enterprise and personal initiative would prefer that such homes be organized and operated by private agencies; in the case of dentists by the American Dental Association.

In other days the aged, the infirm, the retired, were often required to live with their children. This arrangement was seldom satisfactory to any of those involved. At present, modern housing does not permit this arrangement in most cases. Family homes are smaller and more expensive to build and maintain than they were even 17 years ago when we first published on this subject. Two families living in close quarters under one roof is neither a good condition for the young family that is making its own plan of life nor for the parents who have different interests and habits.

Dentists can be proud of the enlightenment of the American Dental Association. In matters of social and economic progress, the Association has the respect of the public, members of legislative bodies, and other professional groups. The Association now has the opportunity to pioneer in another vital area and make plans to create a retirement home for its members.

Members of the House of Delegates have three months to make inquiry among their own dental society membership to test the sentiment for a retirement home project. If there is no grass-roots interest in such an undertaking, the delegates will be ready to express this attitude at the Miami meeting. If there is an approval of the principle of retirement homes the delegates will wish to pass suitable measures to explore the possibilities of such an enterprise for future action. On their own initiative members should express their ideas directly to the delegates from their state society.

Edward J. Ryan

# Q ASK Oral Hygiene A

**Please communicate directly with the department Editors, V. Clyde Smedley, DDS, and George R. Warner, MD, DDS, 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.**

## Erosion

Q.—I have a patient whose lingual surfaces of the upper teeth are eroded, especially the six anteriors. The enamel on the lingual surfaces of the centrals and laterals is completely gone, and partly gone on the cuspids, bicuspids, and first molar. The lower teeth do not seems to be affected.

The physician says he has a hyperacidity. Is there any treatment you could recommend for this condition, or will the teeth continue to erode?

I am considering putting three-quarter crowns on the front teeth. Do you think that would save them?—C. N. N., Wisconsin.

A.—The case of the loss of lingual enamel of the maxillary incisors cited in your letter is identical with cases of patients who have taken dilute hydrochloric acid through a sipper. The use of a sipper is advised to protect the enamel of the teeth. Unfortunately, when a sipper is used the tongue holds the acid against the lingual surfaces of the maxillary incisors and cuspids.

In cases of regurgitation of the acid contents of the stomach, the lingual surfaces of the mandibular teeth suffer the greater loss of enamel, as compared to the maxillary teeth.

I cannot understand how a so-called hyperacidity can have the limited destructive effect on tooth enamel described in your case. However, it would seem probable that the destructive action will continue, but much more slowly on the dentine.

In a case, such as you describe, full jacket crowns were used to restore and protect the teeth, and they have proved satisfactory in every respect.—G. R. WARNER

## Bruxism and Thumb Sucking

Q.—A patient of mine has an 11-month-old boy. He eats and sleeps well, has never had any of the childhood diseases, plays, and is content. However, he grinds his teeth during his sleep, and also when he is awake. He also sucks his thumb.

How can you explain these symptoms in a healthy, contented child; and what would you suggest to correct them?—H. B. S., Massachusetts.

A.—The case presented in your letter has the distinction of being the only case of night grinding or bruxism in an infant with only eight teeth that has come to my attention.

In the adult, bruxism is usually the result of a malocclusion or some type of nervous tension. It may be that nervous tension is the cause in your case of both the bruxism and thumb sucking. Consultation with the child's pediatrician might be helpful.

It is not considered wise to do

anything radical about thumb sucking in such a young child. A watchful mother can remove the thumb from the mouth after the baby has gone to sleep at night, which is of some help in overcoming the habit. —G. R. WARNER

### Missing Permanent Teeth

Q.—I am writing to you in regard to two brothers, age 10 and 8, both of whom are lacking some permanent teeth —the lower centrals in the 10-year-old, and lower bicuspids in the 8-year-old. These facts are confirmed by x-ray study. The patients are of a family of 5 children, all born rather close together. The teeth they have are strong and healthy looking.

What kind of an appliance should be made for the 10-year-old, who does not have any permanent centrals? Also, what would be best for the 8-year-old boy? His deciduous premolars are about to drop out.

These children are healthy and husky, and have always been given proper food and care. The parents' teeth seem to be of good structure. Is heredity the only reason for these things? I have never run across two similar cases in my fifty years of practice. I should appreciate your expert opinion.—L. A. S., Indiana.

A.—I have consulted my good orthodontist friend, Doctor William R. Humphrey, about your two boys missing permanent tooth buds; and he and I agree that at present you should fill these cavities in the deciduous teeth and conserve them as long as possible. Eventually, if and when these deciduous molars are lost, will be time enough to replace them with either fixed or removable bridges.

The same thing holds for the missing lower incisors. Do nothing at present. The eventual decision will depend upon what the situation looks like after permanent teeth are all in place.—V. C. SMEDLEY

### Extrusion Displaces Bridge

Q.—I have a patient, a woman about 35, who had an upper anterior bridge for several years. The bridge replaces the right central; the left central abutment is a full acrylic veneer crown over a gold coping; the pontic is acrylic over a gold frame, with a rest lug fitted into a recess on a full acrylic veneer crown over a gold coping on the right lateral.

Recently the patient came into the office and complained that the bridge had slipped out of place. Upon examination, it appeared that the left central had erupted about ¾ mm, and that the rest lug had come down out of the recess provided for it. The crowns are firm on both teeth. Her other teeth are in good repair, and a roentgenogram of the anterior teeth is negative. She had this dentistry done out of town before I came here about seven years ago, but I have taken care of her and her family since then and they are interested in good oral hygiene.

Can you advise as to the possible cause of such a condition, and is there any treatment other than reconstruction of the bridge?—F.A.M., Montana.

A.—Inasmuch as your roentgenogram of the maxillary incisors does not reveal any alveolar resorption to account for the left central incisor having extruded enough to allow the loose attachment of the right end of the bridge to drop out of its seat, we will have to think of some other cause.

The one thing that might be the cause is occlusal trauma, which may be caused directly from the

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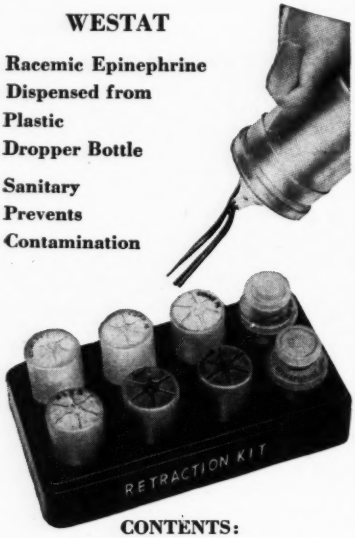


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front teeth, or may be referred from the back teeth.

If the extrusion of this left central is partly labial, disoccluding the tooth and having the patient wear a small cotton pad on the labial surface at night would restore the tooth to its normal position. I used this treatment on a left central maxillary incisor about ten years ago and it has stayed in place ever since.

Another thing to consider in your case: if you should make a new bridge, what assurance do you have that the anchor tooth will not extrude again if you do not discover and correct the cause of the present extrusion?—G. R. WARNER

---

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### ANSWERS TO QUIZ CLII

**(See page 47 for questions)**

1. (a). (Peyton, F. A.: Controlled Water-Addition Technic for Hygroscopic Expansion of Dental Casting Investment, JADA **52**:160, February 1956)
2. True. (Frank, Leonard: The Opening Axis of the Jaw, DENTAL DIGEST **62**:16, January, 1956)
3. (c). (Accepted Dental Remedies, 21st Ed., American Dental Association, 1956, page 169)
4. One third of the apical end. (Blair, V. P. and Ivy, R. H.:

(*Continued on page* 68)

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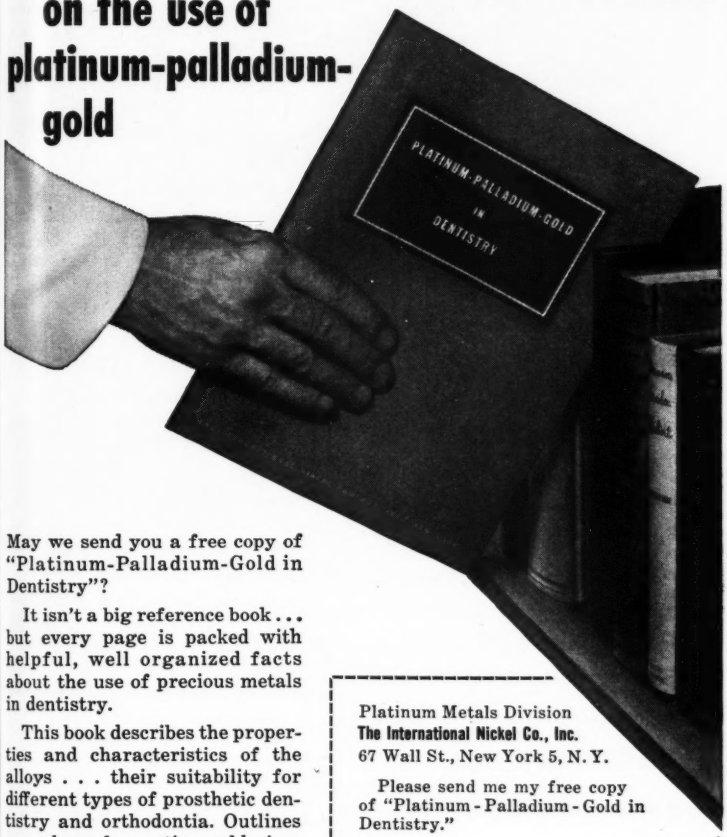


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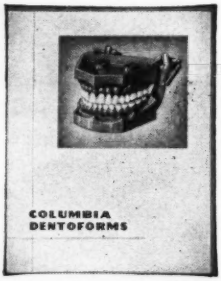


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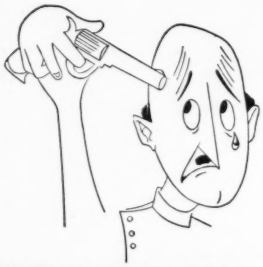

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(*Continued from page* 66)

Essentials of Oral Surgery, 4th Ed., St. Louis, The C. V. Mosby Company, 1951, page 138)

5. (b). (Skinner, E. W. and Jones, P. M.: Dimensional Stability of Self-Curing Dental Base Acrylic Resins, JADA **51**:430, October 1955)
6. No. (Rowbotham, G. F.: Treatment of Trigeminal Neuralgia, Med. Illus. **9**:440, July 1955)
7. Lack of oxygen. (Tausig, D. P.: Application of Anesthetics and Analgesic Agents to Dental Pain, JADA **54**:398, October 1955)
8. True. (Moulton, G. M.: Esthetics in Anterior Fixed Bridge Prosthodontics, JADA **52**:37, January 1956)
9. (a), (b). (Archer, W. H.: A Manual of Oral Surgery, Philadelphia, W. B. Saunders Company, 1952, page 295)
10. The palatine process of the maxillae and the horizontal plate of the palatine bones. (Sicher, Harry: Oral Anatomy, St. Louis, The C. V. Mosby Company, 1949, page 83)

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# Dentists in the NEWS

*San Francisco (California) News:* The Army has honored Major General Roy A. Green with a Presidio farewell ceremony marking his retirement as commanding general of the California National Guard's 49th Infantry Division. He is the only dentist to hold a divisional command in the state guard.

*Shelby (North Carolina) Star:* Doctor Hubert S. Plaster served as a discussion leader in the First Aid and Water Safety section of the annual convention of the American Red Cross in Washington, DC. He also served as representative of the Cleveland County Chapter at the national meeting. Doctor Plaster is currently completing 31 years of service to the local Red Cross Chapter, having begun in 1926 as Water Safety instructor.

*Erie (Pennsylvania) News:* The pioneering spirit of Doctor and Mrs. Ross Garman of Erie has taken them to Okinawa, where they will make their permanent home. The couple spent a year and a half on Okinawa while Doctor Garman was serving with the United States Army Dental Corps. They liked the climate so well and made so many friends among the people there that they decided to return.

Mrs. Garman speaks Japanese fluently, and taught English in a native school in Okinawa. She will train some of the native girls to speak English and to assist her husband, who will practice dentistry among the civilians.

*Long Beach (California) Press Telegram:* A civic award plaque has been presented to Doctor Godfrey Pernell for his "humanitarian philosophy and participation in civic and community affairs both in Long Beach and Los Angeles."

Doctor Pernell was a pioneer in Los Angeles in a unique multi-racial group of dentists and aids who provide dental care for about 15,000 culinary union workers. As one of 60 dentists, technicians and ancillary workers, he took part in the first prepayment dental plan founded in the United States.

*Boys Town (Nebraska) Alumni News:* Doctor Frank Carlotto was a boy of 13 when he arrived at Boys Town from Wisconsin in December 1935. He often confided in the late Father Flanagan regarding his ambition to become a dentist, and upon graduation from high school he was happy that a position had been obtained for him in a dental laboratory in the State of Washington. Then came World War II, and after four years in the United States Air Force, Doctor Carlotto began his predental studies at the University of New Mexico.

Today Doctor Frank Carlotto is the resident dentist at Boys Town. He is happy in his work, and will be the first to tell anyone that the dental facilities offered to the residents of Boys Town are as fine as can be obtained anywhere in the world.

*San Antonio (Texas) Light:* A Lackland wing parade and review recently honored the retirement of Colonel Arthur H. Schmidt, who has headed the base hospital's dental laboratory and prosthetics service. Colonel Schmidt has accepted a civil service post as director of the

(*Continued on page* 72)

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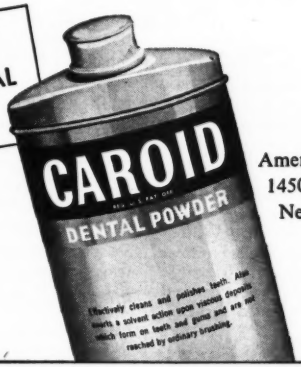


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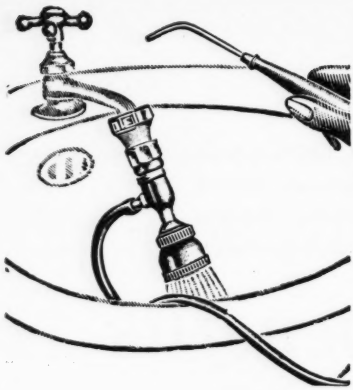

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Air Force School of Prosthetic Dentistry, to be set up at the Lackland 3700th USAF hospital.

Following publication of his professional papers and articles in England, France, Germany, and Holland, as well as the United States, Colonel Schmidt was given the "A" classification for military dentists, the highest rating possible. His biographic sketch appears in WHO'S WHO IN AMERICA, AMERICAN MEN OF SCIENCE, and AMERICA'S DENTAL LEADERS.

*St. Petersburg (Florida) Times:* The Gulf Terrace Restaurant at Bradenton Beach has been bought by Doctor Harold Hutchins, formerly of Ohio. Doctor Hutchins plans to take his state examination and practice in Bradenton, and Mrs. Hutchins will help manage the restaurant, which is located on the Gulf with a sand beach directly behind it.

*Newark (New Jersey) News:* Doctor Elliot Cort, supervisor of the Butler Ground Observer Post, attended a 2-week instructor training course at Tyndall Air Force Base in Florida. He was the only civilian from New Jersey at the installation for this purpose. The objective of the course is to train qualified, selected officers, airmen and key men in methods, procedures, functions and the public relations of the GOC program of the Air Defense Command.

*Torrington (Connecticut) Register:* Doctor William F. Hayes of Meriden, took office on July 1 as governor of District 798, Rotary International, and will serve for the 1957-58 fiscal year. As district governor, he will coordinate activities of 40 Rotary clubs.

*Oakland (California) Tribune:* Doctor Max Kameny of Oakland has been appointed chairman of the professional division for the 1957 United Crusade campaign in Alameda County. Doctor Kameny will head the solicitation this fall among such groups as the Alameda County Dental Society, the Alameda County Bar Association, Optometric Association, and the Alameda-Contra Costa Medical Association. This division of

(*Continued on page* 74)


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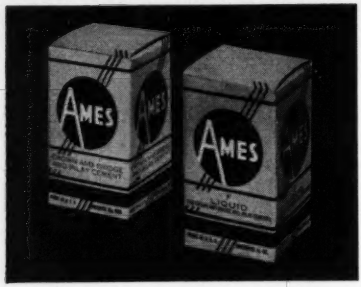


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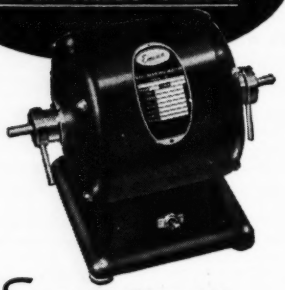

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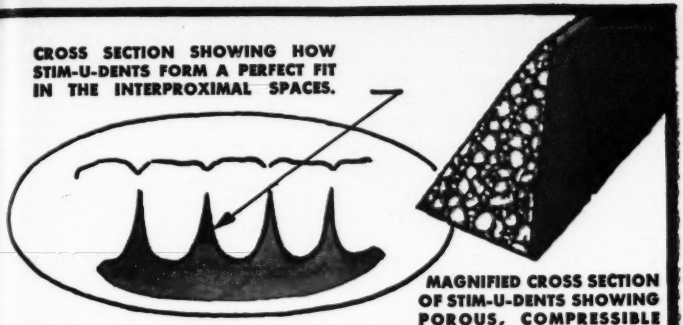
*Seattle (Washington) Post Intelligencer:* Have bus, will travel—so says Doctor Jack Monroe of Pomona, California. The bus has been converted from a 1946 model into a rolling home with every comfort. It sleeps five, has plumbing, a heating system, radio and tape recorders, television, and a kitchen. Doctor Monroe has done some extensive traveling in his luxurious bus—about 12,000 miles—to such varied points as Alaska and Yellowstone Park. He has done most of the remodeling himself on weekends. Because it was originally designed as a bus, the outfit can cruise at speeds of some 75 miles an hour. Doctor Monroe likes to get to his destination, not only in comfort, but in good, safe time; for on arrival, he wants to have as much time as possible for fishing, hunting, and other outdoor recreation.

*Nashville (Tennessee) Banner:* A Nashville orthodontist, Doctor Oren A. Oliver, has received the Albert H. Ketchum Award at the meeting of the American Association of Orthodontists in New Orleans. In his acceptance speech Doctor Oliver urged that orthodontists look forward to still higher standards. Pointing to the vast increase in public acceptance of dental health as a necessity for general health, Doctor Oliver paid tribute to present achievements. But he declared: "Our work has only begun. We must look forward to greater heights to climb."

*Birmingham (Alabama) News:* During a recent visit to the University of Alabama School of Dentistry, Doctor See Sirisinha, dean of the School of Dentistry and University of Medical Science in Bangkok, Thailand, praised the school for its help in training Thailand students, and presented a plaque to the University's dental dean, Doctor J. F. Volker. Other schools in the United States have special government-backed arrangements for training Thai students—with the University of Alabama it is just a matter of friendship.

(*Continued on page 76*)



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The school Doctor Sirisinha directs now has 33 full-time faculty members, about sixty-five dental students, and sixty dental hygienist students. A majority of the dental students are women, partly because women far outnumber men in the Thailand population.

*Kansas City (Kansas) Times:* Adoption proceedings are under way in Grundy County, Missouri, and Doctor Robert N. Davis of Kansas City, expects permanent adoption papers for three orphans early next year. The children are Gordon Andrew, 3; Bradley Scott, 2; and Ramona Kay, 5 months. They were left orphans as the result of a tragic accident. Doctor and Mrs. Davis have another daughter, Chata, 11 years of age. There were about fifty couples who wished to adopt one or two of the children, but only Doctor and Mrs. Davis wanted the whole family.

*Houston (Texas) Chronicle:* After traveling to remote spots of the world gathering information about witch doctors and their practice of voodoo, occultism, sorcery, and black magic, Doctor Harry B. Wright has written a book entitled WITNESS TO WITCHCRAFT, published by Funk and Wagnall. Whatever they may be called—ngombo in West Africa, curandeiro in South America, or dukun in Java—Doctor Wright found that witch doctors had this in common: They are master psychologists and perform strange rituals of healing with a primitive knowledge of medicine which, in many instances, defies explanation.

*Houston (Texas) Post:* Identical, or perfect mirror image twins, Harley and Howard Graff, have received their doctor of dental surgery degrees from the University of Texas Dental Branch. They look so much alike that their parents kept getting them mixed up until they were 18. The only three professors who can tell them apart are observant dentists who finally detected two porcelain crowns on the left side of Harley's mouth.

*Kansas City (Kansas) Star:* Gifts of $8150 to the Doctor Roy J. Rinehart

(*Continued on page 78*)

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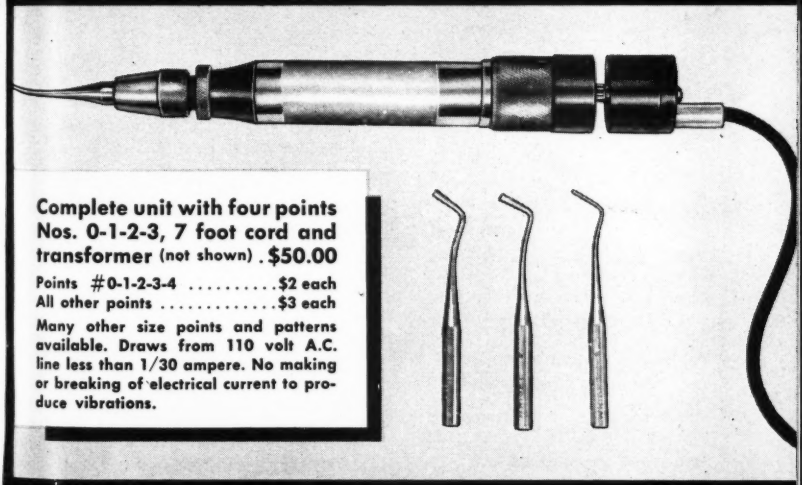

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foundation of the University of Kansas City school of dentistry were announced at the first meeting of the directors of the organization. The largest gift was $5000 from Doctor George Hollenback, Encino, California, a 1905 alumnus of the school, and a close friend of Doctor Rinehart, who died March 22. Other gifts included $1000 from Doctor Lex Moore, Harrison, Arkansas, recently named a consultant in oral surgery to the school; $1000 from Doctor C. J. Brown, and $1000 from Doctor Robert Allen, both of Kansas City, Missouri.

The foundation plans to raise funds for construction of a 1½-million-dollar dental building on the Kansas City University campus.

Awards for items submitted for this month's DENTISTS IN THE NEWS have been sent to:

B. Vellat, 508 West 62nd Street, Seattle 7, Washington

Mrs. Nina Thornton, 309 North Washington Street, Shelby, North Carolina

Helen Griffith, 209 East Lincoln, Tullahoma, Tennessee

Redmond C. Cochrane, DDS, Medico-Dental Building, Palo Alto, California

Meredith E. O'Brien, 583 Montclair Avenue, Oakland 6, California

Edith R. Brown, 515 72nd Avenue, St. Petersburg, Florida

Mrs. Edith M. Crabtree, 2418 Bank Street, Louisville 12, Kentucky

Mrs. E. V. Jackson, 8149 Craig, Overland Park, Kansas

Mrs. H. M. Saunders, 3839 Delta Avenue, Long Beach 10, California

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Mrs. Evelyn Bondreaux, 713 Parker Road, Houston 22, Texas

Mary Martinotti, 59 Lincoln Avenue, Torrington, Connecticut

George Preston Moore, Lock Box No. 69, London, Ohio

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